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[Oregon State Health Division - AIDS and Health Care Law] [loose]

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Kris - do you want this retyped for Sept. 6th?

Yes, please

Marge - please retype this speech adding Kris's notes.

GOVERNMENT INITIATIVES

AIDS and Health Care Law - June 18, 1986

Kristine M. Gebbie, R.N., M.N.
Assistant Director

attention to p.h. law ... TB example — Badge & gun
syphilis example

1) HTLV-III/AIDS Task Force

Membership - all involved gov't agencies - all directly affected segments of community

Purpose - proposed to legislature what $'s or legal changes might be needed

Current Activities - rough draft --- demographics

2) Other policy resources -

Oregon AIDS Task Force

Community AIDS groups

Public Health Advisory Board

ASTHO and affiliates

CDC

need to localize discussion
lowest nat'l commondenominator
does not always apply —
Texas - no records protection
NY - IV drug user care needs —

3) P.H. Program issues - trying to keep focus on arena where control can happen ... not lab research / illness Rx

- how best to use proven public health methods appropriately to limit spread of the HTLV-III virus (example - contact notification) not tracing — record keeping — dealing rumor mills — use of laboratory test
- how best to integrate into programs, new, innovative methods developed by or acceptable to those at highest risk of HTLV-III infection (example - education on safer sex practices) anonymous services
- how best to use existing structures or programs to conserve resources (example - sexually transmitted disease programs) can the too mix ? drug abusers ? quarantine ? services to women ?

4) Legislative issues (anticipated)

- funding for both prevention and care
- public health records protection
- protection of civil rights.

GOVERNMENT INITIATIVES

AIDS and Health Care Law - June 18, 1986

Kristine M. Gebbie, R.N., M.N.
Assistant Director

1) HTLV-III/AIDS Task Force

   Membership

   Purpose

   Current Activities

2) Other policy resources -

   Oregon AIDS Task Force

   Community AIDS groups

   Public Health Advisory Board

   ASTHO and affiliates

   CDC

3) Program issues -

   - how best to use proven public health methods appropriately to limit spread of the HTLV-III virus (example - contact notification)

   - how best to integrate into programs, new, innovative methods developed by or acceptable to those at highest risk of HTLV-III infection (example - education on safer sex practices)

   - how best to use existing structures or programs to conserve resources (example - sexually transmitted disease programs)

4) Legislative issues (anticipated)

   - funding for both prevention and care

   - public health records protection

AIDS and Health Care Law
June 18, 1986

Responses to AIDS Seminar

Resource Notebooks:	Name	Position, Organization
	1. Theresa Wright, Esq.	Cascade AIDS Project
	2. Tom Price	Mt. Hood Community College Mental Health
	3. Bruce Posey, Esq.	Pacific Northwest Bell
	4. Dr. Samuel Beall	Vancouver Clinic
	5. William Bishop	Women's Clinic of Vancouver
	6. Roger Garretson	Vancouver Clinic
	7. Samuel Morse	Health Systems Group
	8. Garrett Netzer	Evergreen Medical Systems
	9. Stephen Schuber, Ph.D.	Editor, VA Practitioner
1	10. Victor Fox	Mult. County Health Dept.
1	11. Jan Kolden	Mult. County Health Dept.
	12. Bernard Merrill, Esq.	
1	13. Jim Whiting	Ass't Admin., Holladay Park Medical Center
1	14. Scott Palmer	Director, Marketing & Planning, Mt. Hood Medical Center
1	15. Gary Daniels	Manager, Care Ambulance, Inc.
1	16. Dennis Mason	Manager, Care Ambulance, Inc.
	17. Pedro Estrada	Manager of Human Resources, Holladay Park Medical Center
1	18. Gloria Bryan	Utilization Review Coor. CareMark Services
	19. Karen Kohlhof	Associate Director, CareMark Services

Resource Notebooks:	Name	Position, Organization
1	20. Dave Donner	Human Resources, HealthLink
1	21. Janelle McLeod	Psych. MH Nurse Practitioner/ RN SEMH. Network
	22. Karen Peters	Psych MH Nurse Practitioner/ RN SEMH. Network
	23. Claudia Floyd	Personnel Services Coordinator, VNA
	24. Donna Cassidy	Manager, Sexually Transmitted Disease Center, Multnomah County Health Department
1	25. Richard D. Faus	Hospital Atty, Newberg Comm. Hospital
1	26. " "	Repre. of Newberg Comm. Hospital
	27. " "	Repre. of Newberg Comm. Hospital
	28. Dr. Douglas Beers	Ass't. Chief of Medicine, Emanuel Hospital
	29. Dr. Mark Loveless	Chairman, Oregon AIDS Task Force
	30. Terrence Kallfelz	Director, Risk Management, HealthLin
	31. Bev Smith	HealthLink
1	32. Ronald Brown, Esq.	VA Ass't District Council
	33. " "	" " "
	34. " "	" " "
1	35. Tom Brand, Esq.	Brand & Larson, Salem Hospital
1	36. Gene Sheggeby	Lab Director, North Lincoln Hospital
1	37. Marvin Heskett	Director of Nursing Services, N. Lincoln Hospital
1	38. Terry Yost	Infection Control Nurses
	39. Cleone Jacobsen	Infection Control Nurses
1 pd.	40. Nancy Bergeron	Personnel Director, Metropolitan Clinic
1	41. Virginia Williams	Director, Risk Management, Sacred Heart Hospital

Resource Notebooks:	Name	Position, Organization
1	42. Judy Lauer	Risk Manager, Emanuel Hospital
1	43. Jeanne Gould	Program Manager, Multnomah County Health Services
	44. Joghne Bales, Ph.D.	Psychologist, Mother of AIDS patient
	45. " "	" "
1 pd.	46. Maryanne Erb	Claims Manager, Admin. & Insurance, Inc.
1	47. Julie Hill	Executive Director, Marion-Polk County Medical Society
1	48. Gerri Wardinski	Infection Control Nurse, Tuality Community Hospital
1	49. Hal Holt	Manager, Human resources S.W. Hospitals, Vancouver
	50. Verla Cowan	Infection Control Coordinator, S.W. Hospitals, Vancouver
	51. Joan Freeman	Certified Infection Control Officer, Oregon Health Sciences University
1	52. Carol Hollister	Admin. Ass't, Mt. Hood Medical Center
1	53. Joyce Foster	Sacred Heart Hospital
1	54. Roberta Kalbfleisch	Sacred Heart Hospital
1	55. Scott Volker	Director of Health, Emanuel (280-4473)
1	56. Michael Gold	General Manager, Dentists Benefits Corporation
1	57. Alex M. Byler, Esq.	Corey, Byler, Rew, Lorenzen & Hojem (Pendleton, OR)
1 pd.	58. Margaret Dragoon, RN	Nurse Epidemiologist, Oregon Health Sciences University
1 pd.	59. Harriet Homan	Nurse Epidemiologist, Emanuel Hosp.
1	60. Gary L. Oxman, M.D.	Medical Director, Multnomah County Health Services Division
	61. " "	" " "
	62. " "	" "

Resource Notebooks:	Name	Position, Organization
1	63. Monica Delaney	Mt. Hood Medical Center
1	64. " "	" " " "
	65. " "	" " " "
	66. Pat Beham	HealthLink Administration
	67. Stacy Armbruster	HealthLink Administration
	68. Mavis Van Delicht	
1	69. Tim Peck	Executive Director, RAIN (Regional AIDS Info Network)
1	70. Ray Myers	Director of Student Services for Salem Public Schools
1	71. Sharon Schlageter, R.N.	Charge R.N., Woodland Park Hosp.
	72. Teresa Newell, R.N.	Relief Charge R.N., Woodland Park
1	73. Virginia Buchanan	Ass't Admin, McMinnville Hospital
1	74. Jo Baker	Employee Health Coordinator Salem Hospital
1	75. Joanne Jackson	Epidemiologist, Providence Hospital
	76. Kenneth Maestretti,	Ass't Admin., Human Resources, Providence Hospital
	77. Coleen Fowler	Case Manager, New Nursing Concept
1	78. L.W. Pearlman	Asst. Attorney General, Dept. of Justice

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AIDS AND HEALTH CARE LAW

A Health Care Law Seminar
on the Legal Issues for Health Care Providers
posed by
Acquired Immune Deficiency Syndrome

SPONSORED BY

**Spears, Lubersky, Campbell,
Bledsoe, Anderson & Young**

**WEDNESDAY, JUNE 18
8:30 AM - 12:00 Noon**

**HILTON HOTEL
PORTLAND, OREGON**

Please check on
their deadline
for handout
materials —
No later than June 13
BF June 1

SPEARS, LUBERSKY, CAMPBELL, BLEDSOE, ANDERSON & YOUNG

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OF COUNSEL
JOHN B. CROWELL, JR.

*MEMBER OREGON AND WASHINGTON STATE BARS

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OUR FILE NO.

PLEASE REPLY TO PORTLAND OFFICE

May 9, 1986

ADMINISTRATOR
Oregon State Health Division

	ACTION	FYI	FILE
Admin.			
H.O.			
Exec. Asst.			
PIO			
Mgt. Asst.			
Other			

RECEIVED
MAY -9 '86

TO: AIDS Seminar Speakers

FROM: Theodore C. Falk

Enclosed is a description of the seminar "AIDS And Health Care Law" at which you are speaking on the morning of June 18. The seminar will be in the Hilton Hotel in downtown Portland.

Item 6 of the description describes each speaker's topic. Feel free to revise the paragraph describing your speech and return your revisions to me.

Item 7 on the description includes brief biographical statements. Please send me a resume or thumb-nail biographical sketch if you have not already done so.

Item 8 of the description is a schedule which gives the time and suggested length of your presentation. Remember we would like all speakers, if possible, to stay for the panel discussion in the last half hour.

Item 9 describes the resource notebook we will prepare. The attorney speakers will prepare outlines of their talks. I encourage the guest speakers to do so as well. We will also reprint in the resource notebook any published materials that speakers wish to submit.

We have not yet publicized the seminar, because we were waiting for clearance from the Oregon State Bar on the issues of legal ethics involved. We have now obtained that clearance from counsel for the Bar.

We will be sending out an announcement, based on the enclosed, to the members of the Oregon Association of Hospitals and the Oregon Society of Hospital Attorneys. Because the announcement will be based on the enclosed description and will be sent to the printer on Monday, please call me if you want any changes in the announcement.

Call me or Nelson Atkin if you have any questions.

Very truly yours,

Theodore C. Falk

Enclosure

cc: Nelson D. Atkin, II

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OUR FILE NO.

PLEASE REPLY TO PORTLAND OFFICE

May 8, 1986

HEALTH CARE LAW SEMINAR

"AIDS AND HEALTH CARE LAW"

(1) Summary

This describes a seminar to be sponsored by the Spears, Lubersky law firm on the legal issues for health care providers posed by Acquired Immune Deficiency Syndrome ("AIDS"). The seminar will be aimed at hospital and health care executives and attorneys and will be open to all interested persons.

(2) Interest in the Topic

Fascination with the legal aspects of AIDS is running at a high pitch. Every week the mail brings a new announcement of a national conference on the subject. Despite the relatively small number of cases in Oregon to date (about 75 diagnosed as full-blown AIDS, half of whom have died), several government agencies have devoted considerable resources to gathering information, promulgating suggested policies, and educating the public on the disease. The number of cases is doubling about every year, and the medical and social costs of each case are enormous. AIDS is an epidemic that raises troubling questions of public policy. Many people have legal questions on how to deal with the disease.

An increasing number of hospitals and other health care providers will have patients or employees with AIDS. Health care institutions are concerned about their legal duties both as employers and as providers of care.

(3) Purpose

The seminar will be an educational service for our clients, friends, and other interested persons. The seminar will:

A. Transmit nationally developed legal analysis,

B. Develop distinctive materials on Oregon law, and

C. Emphasize the connection between AIDS and legal analysis of related but less topical issues.

(4) Format

The seminar will be one-half day long, on the morning of Wednesday, June 18. It will be held in a conference room in the Hilton Hotel in downtown Portland. There will be no charge for attending. Resource notebooks will be distributed to the participants either free or at cost. Advance registration will be encouraged to facilitate planning, to assure sufficient copies of the resource notebooks, and to allow preparation of a list of attendees.

(5) Publicity

An announcement of the seminar will be sent to our health care clients and to some of our non-health care clients in their capacity as employers. As for friends, it will be sent to all institutional members of the Oregon Association of Hospitals and at least some members of the Washington Association of Hospitals, to the law schools, to the Oregon and Washington medical schools, to publications aimed at the physicians in the area, to members of the Oregon Society of Hospital Attorneys and selected other members of the bar, and to other persons professionally involved with AIDS and health care.

(6) Topics

The following are the topics we have suggested the speakers discuss:

A. Introduction and Master of Ceremonies: Anderson.

B. Biology and Epidemiology: Foster.

Because most participants will already be familiar with the rudimentary facts about the disease, this guest speaker will present medical information of particular relevance to legal policy. Areas to be covered include incidence in Oregon, rate of increase, danger from secondary and opportunistic infections, implications of seropositivity, and the sequence from infection to seropositivity to AIDS-related-complex ("ARC") to full-blown AIDS.

C. Right to Treatment and Duty to Treat: Falk

This attorney speaker will discuss the consequences of classifying AIDS as venereal disease, including Oregon's statutory right to free treatment of veneral disease. This speaker will also consider whether hospitals and other medical providers (such as dentists) have a duty to treat AIDS patients.

D. Public Health and Reporting Laws: Schade

This guest speaker will discuss state reporting laws, local laws and policies, laws relating to sexual and communicable diseases, occupational safety and health laws, and hospital rules and guidelines.

E. Confidentiality, Privacy and Defamation: Schreiber

This attorney speaker will discuss recent Oregon cases on confidentiality and privacy (Humphers v. First Interstate Bank and Anderson v. KATU), screening of blood and sperm donors, and risk of defamation.

F. Costs Financing and Insurance: Grant

This guest speaker will discuss insurance screening, health insurance coverage, mandated benefits, medical and social costs of AIDS, state and local medical payment programs, and payment for uninsured AIDS patients.

G. Employment, Discrimination and Civil Rights: Atkin

This attorney speaker will summarize the federal and state civil rights statutes and rules (especially the laws protecting the handicapped), the applicability of these laws to hospitals as employers and as providers, definitions of

handicap, case law on AIDS as a handicap, pre-employment and employment screening, and defenses to discrimination charges. This speaker will also encapsulate the civil rights laws, discuss which laws apply to hospitals, discuss whether AIDS is a civil rights issue, and discuss law on discrimination against homosexuals.

H. Governmental Initiatives: Gebbie

This guest speaker will discuss existing and proposed government programs in Oregon, legislative proposals to be presented to the 1985 Legislature, and legal policies currently under development. The work of the Health Division's "HTLV-III/AIDS Task Force" will be summarized.

(7) Speakers

The seminar will include both guest and attorney speakers.

The four guest speakers will be government officials. The speaker on biological aspects is the Dr. Laurence Foster, state epidemiologist. The speaker on screening and insurance is Dick Grant, head of the State Health Planning and Development Agency. The speaker on public health laws is Dr. Charles Schade, Multnomah County Health Officer. The speaker on governmental initiatives is Kristine Gebbie, Administrator of the Health Division and chairwoman of the Division's AIDS Task Force. All four of the guest speakers have become considerable experts on AIDS and indeed are the leading public officials in Oregon's public policy debates over AIDS.

The three attorney speakers and the master of ceremonies will be hospital and health care attorneys from the Spears, Lubersky firm. Herb Anderson, master of ceremonies, is Chairman of the American Bar Association's Forum Committee on Health Law. Ted Falk, speaker on the right to treatment, is chairman of the Legal/Civil-Rights Subcommittee of the Health Division's AIDS Task Force. Nelson Atkin is a labor lawyer and has attended a conference in New York City on AIDS and the Law. Mark Schreiber has a degree in public health and developed prepaid health care plans for Blue Cross of Oregon before becoming a litigator and health care attorney.

(8) Schedule

8:30 - 8:40	Welcome and Introductions. .	Herbert H. Anderson, J.D.
8:40 - 9:10	Biology and Epidemiology . .	Laurence Foster, M.D.
9:10 - 9:30	Right to Treatment and Duty to Treat.	Theodore C. Falk, J.D., Ph.D.
9:30 - 9:50	Public Health and Reporting Laws	Charles Schade, M.D.
9:50 - 10:10	Confidentiality, Privacy and Defamation	Mark Schreiber, M.D.S., J.D.
10:10 - 10:25	Coffee Break	
10:25 - 10:40	Costs, Financing and Insurance.	Richard Grant, Ed.D.
10:40 - 11:00	Employment and Discrimination	Nelson D. Atkin, II, J.D.
11:00 - 11:30	Governmental Initiatives . .	Kristine Gebbie, M.N.
11:30 - 12:00	Discussion: Questions and Answers.	Panel

(9) Resource Notebook

We will provide (free or at cost) a substantial notebook of resource materials to those who attend the seminar. This will consist of the agenda, speakers' outlines, reprints of selected research materials, a list of participants, and biographical sketches of the speakers and the firm's health care attorneys.

(10) Further Information

For information about the seminar, contact Ted Falk or Nelson Atkin at Spears, Lubersky.

SPEARS, LUBERSKY, CAMPBELL, BLEDSOE, ANDERSON & YOUNG

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10911-19
OUR FILE NO.

PLEASE REPLY TO PORTLAND OFFICE

Sent 4/24/86

April 22, 1986

Kristine M. Gebbie
Assistant Director of the
Department of Human Resources
Administrator of Health
711 State Offie Building
1400 S.W. Fifth Avenue
Portland, Oregon 97201

Re: Seminar on AIDS and Health Care Law

Dear Ms. Gebbie:

This is to confirm our invitation to you to participate as a speaker at a seminar on the legal issues for health care providers posed by Acquired Immune Deficiency Syndrome ("AIDS"). The audience will consist of hospital attorneys and hospital and health care executives. It will be in Portland at a place to be determined.

The seminar will be held on June 18 from 8:30 AM to 11:30 AM. Please mark that time on your calendar. Please call me or my secretary Gretchen LaVelle to confirm your availability for that time.

calendar
RSVP ops
done 4/24/86

We will be contacting you about the arrangements for the seminar. Meanwhile, contact me if you have any questions about the event. Thank you for your willingness to participate in what I hope will be a thought-provoking session.

Very truly yours,

Ted Falk

Theodore C. Falk

cc: Nelson D. Atkin, Esq.

SPEARS, LUBERSKY, CAMPBELL, BLEDSOE, ANDERSON & YOUNG

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OUR FILE NO.

PLEASE REPLY TO PORTLAND OFFICE

April 30, 1986

MEMORANDUM TO: AIDS SEMINAR SPEAKERS

FROM: Theodore C. Falk

RE: Program

As you know, our program on AIDS and Health Care Law has been set for the morning of June 18. Attached is a tentative program schedule. We hope that all speakers, in addition to making their own presentations, will participate in the panel discussion from 11:30 AM until noon. After the end of the program at noon, the speakers are invited to stay for lunch.

Please send me a resume or thumb-nail biographical sketch from which we may prepare a program announcement.

Very truly yours,

Ted Falk

Theodore C. Falk

sent 5/16/86

Art
did we get a
Hunter of

April 30, 1986

HOSPITAL LAW SEMINAR

AIDS AND HEALTH CARE LAW

June 18, 1986

8:30 - 8:40	Welcome and Introductions. . .	Herbert H. Anderson, J.D.
8:40 - 9:10	Biology and Epidemiology . . .	Laurence Foster, M.D.
9:10 - 9:30	Right to Treatment and Duty to Treat.	Theodore C. Falk, J.D., Ph.D.
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11:00 - 11:30	Governmental Initiatives . . .	Kristine Gebbie, R. N.
11:30 - 12:00	Discussion: Questions and Answers.	Panel

DEPAUL CONFERENCE

PUBLIC HEALTH POLICY & HTLV-III INFECTION

Major criticism - "no national policy"

from p.h. viewpoint it would be surprising if there were-

gen'l policy - no comm. disease babies should live, etc.

all else - state/local specific

laws driven at state level

Early experience - limited # of jurisdictions

others - reporting of some kind

provision of factual information

limited awareness of the tensions between gay community and gov't

perceptions that the virus had a sexual preference

Antibody test triggered major shift -

first specific "thing" which could be done

rapid introduction - ?'s

Blood banking

alternate sites -

don't recommend test but provide site

counselling - who, cost

record keeping -

at least one in most jurisdictions (Illinois late)

some introduction of special laws regarding reporting, records

All states now have cases - (AIDS/ARC #'s)

migration issue

Educational programs -

who should do - work with community groups

materials to use -

what is explicit -

what is erotic - community standards

can sell tampons and douches on TV - not condoms

potential for general spread - issue of speed - inefficiency of transmission to men from women

Work with public institutions whose behavior can shape others:

schools - the absolute guarantee

workplace - discrimination

health insurance

media - the "deadly virus"

the research discovery of the day

AIDS & AFRAIDS - scientists who never say never

the "unknown" category

prisons - 500

hospitals - infection control

ASTHO Role -

interface of state/federal policy

forum for affected groups

does not replace need for state by state deliberation

shaped by high incidence of early experience or more common low incidence?

Major outstanding issues -

1) how to balance
   - research
   - treatment
   - public health

2) within public health -
   - how to use best of existing structure to conserve $'s
   - what kinds of staff, how many
   - to keep in proportion to other programs
   - education - general public
     - health providers
     - at risk populations
       - school kids
       - infected individuals

Legal policy issues -

how widespread to test

reportability - new report narrowest band - reverse of usual

informed consent

anonymity - record keeping

isolation

contact notification

THE OREGON HEALTH SCIENCES UNIVERSITY

MEMO

ADMINISTRATOR
Oregon State Health Division

	ACTION	FYI	FILE
Admin.			
[illegible]			
Exec. Asst.			
PIO			
Mgt. Asst.			
Other			

RECEIVED
AUG 12 '85

Date: August 7, 1985

To: Kristine M. Gebbie, R.N.

From: William A. Fisher, M.D.

Subject: Family Medicine Seminar

We are looking forward to your presentation on Wednesday, August 21, 1985. Our seminars start promptly at noon and end by 1:00 p.m.

The audience is composed of faculty members, residents, medical students, nurses, and guests.

Please contact me at 225-7590 to confirm our arrangements. — I've asked Lacey to do this

Enclosure: Family Medicine Seminar Schedule

nlm:A006.MEM

OREGON HEALTH SCIENCES UNIVERSITY

DEPARTMENT OF FAMILY MEDICINE

Family Medicine Seminars

Wednesdays 12:00 - 1:00 p.m.

Emma Jones Hall - Room 326

July 3, 1985 - "Alphabet Soup, Lean Cuisine, and Just Desserts: Issues and Trends in Health Care Delivery" - presented by Robert B. Taylor, M.D., Professor and Chairman, Family Medicine, OHSU.

July 10, 1985 - "Research in Family Medicine" - presented by Eric Wall, M.D., M.P.H., Assistant Professor, Family Medicine, OHSU.

July 17, 1985 - "Behavioral Sciences in Family Medicine" - presented by Kate Commerford, Ph.D., Clinical Assistant Professor, Family Medicine, OHSU.

July 24, 1985 - "Professional Review of Hospitalized Medicare Patients" - presented by Laurel G. Case, M.D., Clinical Professor, Family Medicine, OHSU.

July 31, 1985 - "Family Medicine Participation in AFS/PCO" - presented by Mr. William Collins, Director, Ambulatory Care and Emergency, OHSU, Ms. Ginny Schmunk, Manager, AFDC-PCO, Clin. Administrator, and moderated by Robert B. Taylor, M.D., Professor and Chairman, Department of Family Medicine, OHSU.

August 7, 1985 - "Malpractice Prevention" - presented by Gary Goby, M.D., Clinical Assistant Professor, Family Medicine, OHSU, (Private Practice, Albany, Oregon.)

August 14, 1985 - "Interviewing for Child Abuse: Child and Caretaker" - presented by Kate Commerford, Ph.D., Clin. Asst. Professor, Family Medicine, OHSU, and Karen Lloyd, R.C.S.W.

August 21, 1985 - "AIDS in Oregon" - presented by Kristine M. Gebbie, R.N., M.N., Administrator of Health Division, Department of Human Resources, and Larry R. Foster, M.D., Deputy State Epidemiologist.

August 28, 1985 - "Preoperative Patient Evaluation" - presented by Margaret S. Vandenbark, M.D., Assistant Professor, Family Medicine, OHSU.

This program has been reviewed and is acceptable for one prescribed hour by the American Academy of Family Physicians."

Family Medicine Grand Rounds will resume August 22, 1985.

nlm:A010.MEM

AIDS IN OREGON

(1) Interest in AIDS

Clinical - diagnosis and management of a new syndrome

too quick or too slow to label immuno-compromised individual

Epidemiological - identifying accurately the extent of the problem - distribution of cases

risk group identification

potential for control

Public Policy - labelling - "Epidemic"?

"highest" public health priority?

"largest" public health problem?

20,000 deaths/yr. in Oregon

8,000 - heart

5,000 - malignancy

2,000 - cerebrovascular

1,200 - unintended injury including motor vehicle

How to appropriately fund research, etc. without distorting priorities, without doing an injustice to public

Public Opinion - range from indifferent (the queers deserve it) to panic (anyone can get it)

Transfusion - associated cases - risks/non-risks

Long term attitudes

8/21/85

Victims/Potential Victims -

Long term support (crossover with other debilitating conditions)

Financing of care

Isolation

Fears of discrimination - jobs

insurance

public services

(2) Facts about AIDS in Oregon - Foster

(3) Policy Questions -

Reportability - Confirmed Disease

ARC

Positive HTLV-III Tests

Reaction to Reports

Confidentiality - confusion with anonymity

Public Education - concern for heterosexual community

(4) Role of Family Physician -

Reporting/consultation on cases

Screening/Education of risk group members

General public (patient) education -

accurate information to patients

Community activities

THE OREGON HEALTH SCIENCES UNIVERSITY

ADMINISTRATOR
Oregon Graduate Institute Division

	ACTION	FYI	FILE
Exec. Asst.			
PIO			
Mgt. Asst.			
Other			

RECEIVED
AUG 23 '85

MEMO

Date: August 28, 21, 1985

To: Kristine M. Gebbie, R.N.

From: William A. Fisher, M.D. WAF

Subject: Family Medicine Seminar

Many thanks for your presentation on August 21, 1985.

Our department appreciates your expertise and time committment.

nlm:A005.MEM

Twas well done - You + Larry make good team -

TV man has just given me a copy of presentation.

It's on 3/4" U-matic if you would like to

review it, let me know -

Thanx again

Bill

See you in Prineville

OPHA
Oct 7, 1985

"6 out of 10 in Oregon Fear AIDS Epidemic" - Oregonian 10-6-85

The issue isn't what is or is not scientifically "real" -
The issue is perception of reality - in the minds of Oregonians
"Epidemic" means a disease leaping from person to person - "raging" through the cities with no realistic mechanism for self-protection - calls to mind the middle ages and ships sitting anchored in a harbor, unable to land.

From the perspectives of either avoidability - long term social costs AIDS is far less "epdiemic" in Oregon than trauma or teenage pregnancy- but those have become background noises to many, and AIDS is the focus.

As Oregon's public health leaders, we have an opportunity to prevent a major occurrence of AIDS in Oregon and a challenge to do so quickly, not waiting for magic bullets but using familiar tools.

We can't "make people understand", but can confront people with the facts.
AIDS - public health opportunity/public health challenge
Public perception of AIDS as a crisis and epidemic will drive our agenda and priorities unless we get ahead of it.

The "deadly virus" - listening to the news - the adjective is almost always there -

The recognition of the range of response to infection with the virus HTLV-III – 13,000 patients diagnosed

1,000,000 presumed infected

San Francisco experience - following group of men enrolled in hepatitis study - 2/3 of those known to have been HTLV-III+ in 70's still well.

Described as iceberg with AIDS as the tip - the analogy may be misleading people to presume all those infected will become ill.

The disease of perverts and criminals -

Though less today, there has been tendency to ignore the problem as much as possible -

It is only affecting homosexuals or drug abusers.

It's only in San francisco or New York or Florida.

The caution demonstrated by public health community in protecting the rights and sensibilities of the homosexual community may have distorted communication to the general public that we are taking good science into account in our policies - anonymity vs. confidentiality.

Where's the "magic bullet" - much media attention has been directed at the search for treatment or a vaccine - The research is essential -

to understand the virus is a key to control,

to treatment - but it can be a distraction from some old fashioned public health actions -

cut transmission of the virus -

Congress has been fascinated by the research proposals - doubling funding when a prominent person died recently, but not funding basics.

The distraction has not been universal - there have been excellent community education efforts in various cities and states - not just "excellent" but useful -

There is evidence that members of risk groups have changed behavior - Drop in STD rate in homosexual community.

We also have a serious complicating factor -

Time lag of evidence-

Community-wide, our expectation of short cued response times leads to a desire for results "now" -

Prove you can help.

The 2-5 year time lag between infection and disease means we can't show results "now".

If education, and increased awareness of AIDS as a sexually transmitted disease are now changing behavior, we will not see certain results for several years.

The treatment community is facing a difficult challenge - assisting seriously and terminally ill patients without specific medications to both stop the replication of the HTLV-III virus and restore the patient's immune system.

The public health community is challenged also but does have a better beginning -

We have clear information about routes of transmission - hidden under the polite term "body fluids" is the fact that blood and semen are the vehicle of transmission.

We can deliver a positive message - if you do not share I.V. needles or other blood contaminated items, if you limit your sexual partners, if you protect yourself during sexual encounters with those who may be

infectious, you <u>can</u> protect yourself. You can avoid the disease.

you are protected if

We have a good laboratory test of infectiousness. Used in appropriate situations (with the worried well who may have been exposed via past sexual practices, used in conjunction with contact tracing) it can identify individuals most in need of hearing and understanding the message.

The message must connect with those at risk, and reassure those not at risk.

What should public health workers and agencies do?

<u>Not</u> wait and see - on the premise that things keep changing anyway.

1) Be educated ourselves -

   There isn't room for the doubtful "I guess I believe, but - - -"

   Not just the epi nurse or the health officer -

   - How's the sanitarian responding to questions about food handling practices?
   - The STD clinic nurse responding to questions about safer sexual practices?

- The immunization clinic staff responding to comments about schools?
- The Administrator to questions about quarantine
- The physician to questions about transfusions

2) Make education local -

So what if the Health Division is writing a policy on AIDS patients in schools, or the CDC a special MMWR on health care workers risks. Those general messages do not mean much unless reinforced at the local level.

Collaboration on inservice for staff of health care facilities. (AIDS precautions are the same as precautions for any blood borne disease)- I didn't connect on that for several weeks -

"Getting ready for AIDS patients" isn't physically/technically difficult - it's the psychology

—Anticipatory planning with local school personnel

Presentation at forum for personnel/health staff from insurance companies, actuarial reasons - maybe - denial - not really

- Incorporation of AIDS Prevention information into <u>all</u> work -

3) Make the services work -

Alternate HTLV-III sites work well to protect the blood supply only if there are no obstacles - if they are difficult to enter, worried, high risk individuals will go back to blood banks - and given the available test, there is a higher possibility that infected blood will get through.

Begin anticipating a case finding, contact tracing program as a basic part of our efforts - we'll begin slowly, using one or two specially selected, trained professionals - but the numbers could get large, and sooner or later the cadre of STD investigators will be involved -

Expect more "opportunities" - for example - potential inductees who test positive and are referred -

Keep the problem in perspective -

New money isn't falling on us like manna from heaven - but some is coming -

We can neither wait and only do what is specifically finded by "The Feds" or drop everything else and chase AIDS.

Local "temperature-testing" will help keep some perspective on the appropriate amount of effort -
AIDS is a sexually transmitted disease
AIDS is a communicable disease
AIDS is a public health, not just a medical treatment issue -

A program of AIDS prevention should be a part of every official health agency's agenda.

I have expressed pride at Oregon's behavior to date - but that may be just the fortuitous fact of our low incidence rate - few Oregonians know (or know that they know) an AIDS patient, or a person who has tested positive to HTLV-III antibodies. I don't think it is only that - we have a responsible media. We have thoughtful officials not only in health agencies but in Education and Corrections. We have concerned health professionals.

But we also have people like the man who believes the New York Times, not the Oregonian and believes his child can get AIDS from helping a classmate wash a skinned knee -

We have the opportunity, the challenge, the mandate - to provide the finest public health services - and make AIDS in Oregon the epidemic that didn't happen - quite.

HEALTH CARE NEEDS OF THE DYING PATIENT
Kristine Gebbie
April 3, 1986

What to offer that is different from other speakers -

quality of life

rights of individuals

technology management

not waiting to focus on any one "category of patient" - elderly, very ill newborn, oncology patient, AIDS patient, trauma victim

Semantics which shape our concept of the process and our role in it -

o use of term "health care" for services to dying - more accurately illness care and supportive services

I would prefer to reserve "health care" for services designed to keep a healthy person well, or make that person even healthier

o Dying patient -

old truism - all suffering from terminal disease of senescence (or living) - quite artificial to separate those near end - why?

possibly needed because many institutions don't separate health care and illness care and base all care on a curative model ex -

As I listen to those involved with hospice care or other "end of life" services, I generally hear described:

1) patient (or family) decision-making - what do <u>you</u> want?

2) minimal use of technology - do I want this machine turned on?

3) multidisciplinary care planning - physician not alone

4) involvement of religious community - what spiritual support?

5) alternate settings (non-hospital) - where would you like to die?

No eg Diagnosis?

Each of these should be critical part of patient care - all the time -

angry at and fascinated by our collective shift into high gear -

pushed by excellent studies in 1960's % providers fear ↓ death

what distinguishes focus on dying pt -

(1) relationship between patient/caregiver

patient outcome leads to shift from living to graceful end

(2) perhaps a more universal theme is "how do I want to use the time

available to me"

System requirement -

Needs of patient can only be met if caregiver's needs are met -

1) clear understanding of our values and readiness to separate

from patient's values

2) acknowledgement of emotional strain and potential consequences

3) appropriate information/education

Linfield College

Portland Campus

ADMINISTRATOR
Oregon State Health Division

	ACTION	FYI	FILE
Admin.			
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Exec. Asst.			
PIO			
Mgt. Asst.			
Other			

RECEIVED
JAN 23 '86

2255 N.W. Northrup
Portland, Oregon 97210-2952
(503) 229-7161

January 9, 1986

Dear Ms. Gebbie,

We are pleased that you will be able to participate in our medical ethics conference "Dying in a Technological Age" on April 3rd and 4th, 1986. Your expertise in this area will help to make this conference a success.

Enclosed is a tenative schedule of the program so that you may plan your presentation accordingly. We expect the audience to be composed primarily of members of the health care community, though we are encouraging members of the general public to attend as well.

If you plan to use any audio-visual equipment we will need to know this in advance. Enclosed is a check sheet which will help us plan according to your needs. If you would like to submit questions for the "post-test" please feel free to do so.

We are pleased to have you as our featured speaker during the conference dinner on Thursday evening at 5:30. Please feel free to contact us if you have any questions or needs with which we may assist you. We are looking forward to your presence in April.

Sincerely Yours,

Jill Daniels RN

Jill Daniels, RN
Conference Committee

LINFIELD COLLEGE
GOOD SAMARITAN SCHOOL OF NURSING in conjunction with
OREGON HEALTH DECISIONS
presents
Their First Annual

CONFERENCE ON HEALTH CARE ETHICS

To Be or Not To Be: Dying in an Age of Technology

April 3 and 4, 1986
Linfield College-Portland Campus
2215 NW Northrup
Portland, Oregon 97210

The First LINFIELD COLLEGE
GOOD SAMARITAN SCHOOL OF NURSING
Conference on Health Care Ethics

To Be or Not To Be: Dying in an Age Of Technology

Modern technology has created both benefits and problems in the fields of health care. Now it is possible for medical technolgy to extend life far beyond the point where natural processes would have brought about a termination. In cases where some hope of recovery and the re-establishment of a quality of life is possible this capability of modern medical technology is undoubtedly of great benefit. However, the very ability to sustain life beyond its natural course can generate difficult ethical issues. What are the criteria by which one decides on continued life maintenance? This question has been and continues to be an important issue of debate in the public realm; it has especially exercised those in the health care fields where the problem has a recurrent immediacy. The purpose of this conference is to explore this problem from multiple perspectives in order to shed light upon some of the ways in which one may begin to think clearly about the issues. Dying in an age of technology creates problems of the deepest moral significance which are the concern not only of the health professionals but of the public as a whole. For this reason, this conference will not only present the thoughts and ideas of experts, but will also provide the public with ample opportunities to become involved in the discussions.

FEATURED SPEAKERS AND EVENTS

Alan Gewirth,Edward Carson Waller distinguished service Professor of Philosophy, University of Chicago; past President of the American Philosophical Association. Professor Gewirth is one of the foremost philosophers in the field of ethics and social philosophy. Among his published works are Moral Rationality,1972, Reason and Morality, 1978, and Human Rights: Essays on Justification and Applications, 1982. He has been honored as a Rockefeller Foundation fellow, a National Endowment for the Humanities Senior fellow, and as a Guggenheim Foundation fellow.

Christine Mitchell, R.N., M.S., M.T.S., Clinical Nurse Specialist, The Children's Hospital, Department of Staff Development and Research. Ms. Mitchell has participated in numerous conferences and symposia dealing with medical ethics and has produced several publications on the subject, including co-authoring the study guide for the film Code Gray: Ethical dilemmas in Nursing. She has also been noted for her collaboration in the production of this prize winning film. Ms. Mitchell is "...interested in exploring some of the tacit assumptions and value choices many of us have regarding the nature of a good death".She will be sharing some of these explorations at this conference.

Peter Y. Windt, Ph.D., Associate Professor of Philosophy, University of Utah. Professor Windt has been a consultant on Ethics and Clinical Practice for the Cancer Rehabilitation Project and a member of the Institutional Review Board at the University of Utah Medical Center. Currently, he has been conducting research on quality of life and medical decision making for elderly patients, in the course of which he has "turned up some interesting results". Professor Windt will be presenting some of these results at this conference.

Film - CODE GRAY: Ethical Dilemmas in Nursing. Code Gray documents four actual situations where nurses confront ethical dilemmas in their work. Because of their pivotal role in the health care delivery system, nurses are confronted daily by conflicting loyalties, responsibilities and expectations. They may experience profound tensions between what they believe they should be doing, as ethical practitioners, and the realitites of day-to-day nursing practice. - Red Ribbon Winner, American Film Festival; First prize, San Francisco International Film Festival; First Prize, American Journal of Nursing Media Awards

Play- "You Never Knew My Father" by Barbara Kay Davidson, featuring the Linfield Players and directed by Jerald Seifert,M.A.. This play will challenge viewers to formulate an operable definition of personhood and human dignity by providing an occasion which will permit and encourage them to draw back the veil and for a brief moment look boldly at the reality of death. For some it will provide an opportunity to explore feelings, questions and beliefs which are generally unheeded. For others, it will provide an impetus to sign a Living Will. And for still others it will provoke serious reflection about the ethics of caring for the dying. Admission free to all conference participants.

Dinner- There will be a special dinner Thursday evening with conference leaders featuring Kristine Gebbe, R.N., Assistant Director, Human Resources; Administrator, Health Division, State of Oregon. Ms. Gebbe will speak on "Health Care Needs of the Dying Patient".(Reservations required - limited seating available.)

OTHER PARTICIPANTS

William Bestor, Ph.D., Associate Professor of Anthropology, Linfield College

Linda Van Buren, R.N., M.N., Director of Hospice Program, Kaiser-Permanente

Judy Colligan, R.N., M.N., Psychiatric Clinical Nurse Specialist, Good Samaritan Hospital

Jill Daniels, R.N., B.S.N., Adjunct Faculty, Linfield College

Garfield DeBardlaben, Ph.D., Psychology Consultant, Good Samaritan Hospital Cancer Rehabilitation Program

Patrick Dunn, M.D., Chairman of Good Samaritan Hospital Bioethics Committee

Frederic Fost, Ph.D., Professor of Philosophy, Linfield College

Dave Frohnmayer, J.D., Attorney General, State of Oregon

Michael Garland, Ph.D., Associate Professor of Community Medicine and Medical Ethics, Oregon Health Sciences University

Kristine M. Gebbie, R.N., Assistant Director, Human Resources; Administrator, Health Division, State of Oregon

Richard Grant, Ph.D., Associate Professor of Nursing, Linfield College

Kevin Hurst, M.P.A., Director of Student Activities and Events, Linfield College

Reverend R.M. Jepsen, D.Min., Associate Chaplain, Good Samaritan Hospital; member of Good Samaritan Hospital Bioethics Committee

Arlene Jurgens, R.N., M.N., Associate Professor of Nursing, Linfield College

Connie Keyes, R.N., M.S.N., Assistant Professor of Nursing, Lindfield College

Tim Nay, M.S.W., J.D., Attorney-at-Law

Frank Nelson, M.A., Associate Professor of Philosophy, Linfield College

Linda Olds, Ph.D., Professor of Psychology, Linfield College

Ron Potts, M.D., Area Medical Director; Vice President, Medical Operations-Kaiser Permanente

Rabbi Emanuel Rose, Temple Beth Israel

Jerald L. Seifert, M.A., Assistant Professor, Linfield College

Stephen Snyder, Ph.D., Associate Professor of Religion, Linfield College

John Thomas, Ph.D., Assistant Professor of Philosophy, Linfield College

Lavaughan Wilson, R.N., B.A., Assistant to the Director, Linfield College

THURSDAY...APRIL 5

8:00 - 8:30 A M	Registration and coffee
8:30 - 8:45 AM	Welcome by Dr. Charles U. Walker, President, Linfield College, and Marge Hanley, Vice President, Good Samaritan Hospital and Medical Center
8:45 - 10:15 AM	Multiperspective Panel: WHAT IS "QUALITY OF LIFE"? * Introduction - John Thomas, Ph.D., moderator * Philosophic - Frederic Fost, Ph.D. * Religious - Rabbi Emanuel Rose * Anthro/Sociological - William Bestor, Ph.D. * Political/legal - Tim Nay, Attorney-at-Law * Psychological - Linda Olds, Ph.D.
10:15 - 10:45 AM	Audience questions - Panel discussion
10:45 - 11:00 AM	Break
11:00 - Noon	Alan Gewirth, Ph.D.: THE RIGHTS OF INDIVIDUALS AND THE RIGHTS OF THE DYING. Introduction by Frank Nelson, M.A.
Noon - 1:00 PM	Lunch - Buffet in Photo Gallery
1:00 - 2:30 PM	Multiperspective Panel: MEDICAL TECHNOLOGY AND ITS IMPACT ON QUALITY OF LIFE * Introduction - Frank Nelson, M.A., moderator * Philosophic - Peter Windt, Ph.D. * Religious - Rabbi Emanuel Rose * Anthro/sociological - Richard Grant, Ph.D. * Political/legal - Tim Nay, Attorney-at-Law * Psychological - Gar DeBardlaben, Ph.D.
2:30 - 3:00 PM	Audience questions - Panel discussion
3:00 - 3:15 PM	Break
3:15 - 3:45 PM	Film - CODE GRAY: Ethical dilemmas in Nursing.
3:45 - 5:15 PM	Michael Garland, Ph.D.: HOW CAN TECHNOLOGY BE MANAGED SO THAT IT ENHANCES THE QUALITY OF LIFE DURING TERMINAL ILLNESS? Peter Windt, Ph.D.: THE ROLE OF QUALITY OF LIFE IN MEDICAL DECISION MAKING. Introduction by Kevin Hurst, M.P.A.
5:15 - 5:30	Audience questions
	OPTIONAL
5:30 - 7:00 PM	Dinner with featured speaker: Kristine Gebbie, R.N., "Health Care Needs of the Dying Patient"
7:00 - 8:00 PM	Play - "YOU NEVER KNEW MY FATHER" * by Barbara Kay Davidson; The Linfield Players directed by Jerald Seifert, M.A. (Sponsored in part by the Metropolitan Arts Commission)
8:00 - 9:00 PM	Panel discussion of play
	* Play presented by permission of Bernard F. and Alva B. Gimbel Foundation and to Plays for Living Division of Family Service Association of America

FRIDAY APRIL 4

8:30 - 9:15 AM	Registration and coffee
9:15 - 9:30 AM	Welcome by Dr. Pamela Harris, Dean of Linfield-Good Samaritan School of Nursing
9:30 - 10:15 AM	Christine Mitchell, R.N.: THE NATURE OF A GOOD DEATH. Introduction by Connie Keyes, M.S.N.
10:15 - 10:30 AM	Audience questions
10:30 - 10:45 AM	Break
10:45 - 11:45 AM	EASING THE DYING PROCESS * Introduction - Judy Colligan, R.N. * Therapeutic touch - Arlene Jurgens, R.N., M.N. and Lavaughan Wilson, R.N., B.A. * Spiritual counseling - Reverend R.M. Jepsen * Hospice - Linda Van Buren, R.N., M.N.
11:45 - 12:15 PM	Audience questions
12:15 - 2:00 PM	Lunch - Buffet in Photo Gallery Oregon Health Decisions annual meeting- open to all conference participants
1:30 - 2:00 PM	Film - "CODE GRAY: Ethical Dilemmas in Nursing"
2:00 - 3:00 PM	SOME PERSPECTIVES ON HOW ACUTE CARE INSTITUTIONS CAN SUPPORT QUALITY OF LIFE UNTIL DEATH: * Introduction - Connie Keyes, R.N., M.S.N. * Peter Windt, Ph.D. * Christine Mitchell, R.N., M.S., M.T.S. * Judy Colligan, R.N. * Patrick Dunn, M.D.
3:00 - 3:15 PM	Audience questions
3:15 - 3:30 PM	Break
3:30 - 5:00 PM	THE CLIENTS ROLE IN ACHIEVING AUTONOMY IN THE DYING PROCESS: RIGHTS AND RESPONSIBILITIES * Introduction - Jill Daniels, R.N., B.S.N. * Ron Potts, M.D., "Living wills and physician directives" * Dave Frohnmayer, J.D., Attorney General, State of Oregon, "Legal rights of the dying"
5:00 PM	Closing remarks-Connie Keyes, R.N., M.S.N.

RESERVATIONS LIMITED! A prompt response will reserve your place

REGISTRATION FORM

Name_____ Tel._____
Address_____

___ $ 35 Thursday and Friday
___ $ 25 One day (Thursday or Friday, please circle)
The above fees include lunch.
Good Samaritan Hospital employees deduct $10 from above fees.
___ $ 5 Continuing Ed. credit (application pending)
___ $ 15 Thursday dinner (limited reservations)

Make checks payable to: Linfield College
Return to: Conference
Linfield College-Portland Campus
2215 NW Northrup
Portland, OR. 97210
NO REFUNDS AFTER MARCH 19

FOR MORE INFORMATION, CALL 229-7161

LOCATION: Nursing Education Building
2255 NW Northrup
Portland, Oregon

PARKING: 2144 NW MARSHALL

SPECIAL THANKS TO:
Associated Students of Linfield College-Portland Campus
Good Samaritan Hospital and Medical Center
Student Nurses Association, Linfield College-Portland Campus
Metropolitan Arts Commission

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OTHER PARTICIPANTS

William Bestor, Ph.D., Associate Professor of Anthropology, Linfield College
Linda Van Buren, R.N., M.N., Director of Hospice Program, Kaiser-Permanente
Judy Colligan, R.N., M.N., Psychiatric Clinical Nurse Specialist, Good Samaritan Hospital & Medical Center
Jill Daniels, R.N., B.S.N., Adjunct Faculty, Linfield College
Garfield DeBardelaben, Ph.D., Psychology Consultant, Good Samaritan Cancer Rehabilitation Program
Patrick Dunn, M.D., Chairman of Good Samaritan Bioethics Committee
Frederic Fost, Ph.D., Professor of Philosophy, Linfield College
Dave Frohnmayer, J.D., Attorney General, State of Oregon
Michael Garland, Ph.D., Associate Professor of Community Medicine and Medical Ethics, Oregon Health Sciences University
Kristine Gebbie, R.N., Assistant Director, Human Resources; Administrator, Health Division, State of Oregon
Richard Grant, Ph.D., Associate Professor of Nursing, Linfield College
Kevin Hurst, M.P.A., Director of Student Activities and Events, Linfield College
Rev. R.M. Jepsen, D. Min., Associate Chaplain, Good Samaritan Hospital; member of Good Samaritan Bioethics Committee
Arlene Jurgens, R.N., M.N., Associate Professor of Nursing, Linfield College
Connie Keyes, R.N., M.S.N., Assistant Professor of Nursing, Linfield College
Tim Nay, M.S.W., J.D., Attorney
Frank Nelson, M.A., Associate Professor of Philosophy, Linfield College
Linda Olds, Ph.D., Professor Psychology, Linfield College
Ron Potts, M.D., Area Medical Director; Vice President, Medical Operations, Kaiser Permanente
Rabbi Emanuel Rose, Temple Beth Israel
Jerald L. Seifert, M.A., Assistant Professor, Linfield College
John Thomas, Ph.D., Assistant Professor of Philosophy, Linfield College
Lavaughan Wilson, R.N., B.A., Assistant to the Director, Linfield College

THURSDAY, APRIL 3

8 – 8:30 AM	Registration and coffee
8:30 – 8:45 AM	Welcome by Dr. Pamela Harris, Dean of Linfield-Good Samaritan School of Nursing
8:45 – 10:15 AM	Multiperspective Panel: WHAT IS "QUALITY OF LIFE"? * Introduction – John Thomas, Ph.D., moderator * Philosophic – Frederic Fost, Ph.D. * Religious – Rabbi Emanuel Rose * Anthro/Sociological – William Bestor, Ph.D. * Political/legal – Tim Nay * Psychological – Linda Olds, Ph.D.
10:15 – 10:45 AM	Audience questions – Panel discussion
10:45 – 11 AM	Break
11 AM – Noon	**Alan Gewirth, Ph.D.:** THE RIGHTS OF INDIVIDUALS AND THE RIGHTS OF THE DYING. Introduction by Frank Nelson, M.A.
Noon – 1 PM	Lunch – Buffet in Photo Gallery
1 – 2:30 PM	Multiperspective Panel: MEDICAL TECHNOLOGY AND ITS IMPACT ON QUALITY OF LIFE * Introduction – Frank Nelson, M.A., moderator * Philosophic – Peter Windt, Ph.D. * Religious – Rabbi Emanuel Rose * Anthro/sociological – Richard Grant, Ph.D. * Political/legal – Tim Nay, Attorney-at-Law * Psychological – Garfield DeBardelaben, Ph.D.
2:30 – 3 PM	Audience questions – Panel discussion
3 – 3:15 PM	Break
3:15 – 3:45 PM	**Film** – CODE GRAY: Ethical Dilemmas in Nursing.
3:45 – 5:15 PM	**Michael Garland, Ph.D.:** HOW CAN TECHNOLOGY BE MANAGED SO THAT IT ENHANCES THE QUALITY OF LIFE DURING TERMINAL ILLNESS? **Peter Windt, Ph.D.:** THE ROLE OF QUALITY OF LIFE IN MEDICAL DECISION MAKING. Introduction by Kevin Hurst, M.P.A.
5:15 – 5:30 PM	Audience questions
	OPTIONAL
5:30 – 7 PM	**Dinner with featured speaker:** Kristine Gebbie, R.N., "Health Care Needs of the Dying Patient"
7 – 8 PM	**Play** – "YOU NEVER KNEW MY FATHER" *by Barbara Kay Davidson; The Linfield Players directed by Jerald Seifert, M.A. (Sponsored in part by the Metropolitan Arts Commission)
8 – 9 PM	**Panel discussion of play**

*Play presented by permission of Bernard F. and Alva B. Gimbel Foundation and to Plays for Living division of Family Service Association of America

FRIDAY, APRIL 4

8:30 – 9:15 AM	Registration and coffee
9:15 – 9:30 AM	Welcome by Dr. Charles U. Walker, President, Linfield College, and Marge Hanley, Vice President, Good Samaritan Hospital & Medical Center
9:30 – 10:15 AM	**Christine Mitchell, R.N.:** THE NATURE OF A GOOD DEATH. Introduction by Connie Keyes, M.S.N.
10:15 – 10:30 AM	Audience questions
10:30 – 10:45 AM	Break
10:45 – 11:45 AM	EASING THE DYING PROCESS * Introduction – Judy Colligan, R.N. * Therapeutic touch – Arlene Jurgens, R.N., M.N. and Lavaughan Wilson, R.N., B.A. * Spiritual counseling – Reverend R.M. Jepsen * Hospice – Linda Van Buren, R.N., M.N.
11:45 – 12:15 PM	Audience questions
12:15 – 2 PM	Lunch – Buffet in Photo Gallery Oregon Health Decisions annual meeting – open to all conference participants
1:30 – 2 PM	**Film** – "CODE GRAY: Ethical Dilemmas in Nursing"
2 – 3 PM	SOME PERSPECTIVES ON HOW ACUTE-CARE INSTITUTIONS CAN SUPPORT QUALITY OF LIFE UNTIL DEATH: * Introduction – Connie Keyes, R.N., M.S.N. * **Peter Windt, Ph.D.** * **Christine Mitchell, R.N., M.S., M.T.S.** * Judy Colligan, R.N. * Patrick Dunn, M.D.
3 – 3:15 PM	Audience questions
3:15 – 3:30 PM	Break
3:30 – 5 PM	THE CLIENT'S ROLE IN ACHIEVING AUTONOMY IN THE DYING PROCESS: RIGHTS AND RESPONSIBILITIES * Introduction – Jill Daniels, R.N., B.S.N. * **Ron Potts, M.D.,** "Living wills and physician directives" * **Dave Frohnmayer, J.D.,** Attorney General, State of Oregon, "Legal rights of the dying"
5 PM	Closing remarks – Connie Keyes, R.N., M.S.N.

FOR MORE INFORMATION: CALL 229-7161

LOCATION: Nursing Education Building
2255 NW Northrup
Portland, Oregon

PARKING: 2144 NW MARSHALL

SPECIAL THANKS TO:
Associated Students of Linfield College – Portland Campus
Good Samaritan Hospital & Medical Center
Student Nurses Association, Linfield College – Portland Campus
Metropolitan Arts Commission

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Name _____ Telephone _____

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The above fees include lunch.
Good Samaritan employees deduct $10 from above fees.
_____ $ 5 Continuing Ed. credit (application pending)
_____ $15 Thursday dinner (limited reservations)

Make checks payable to: Linfield College
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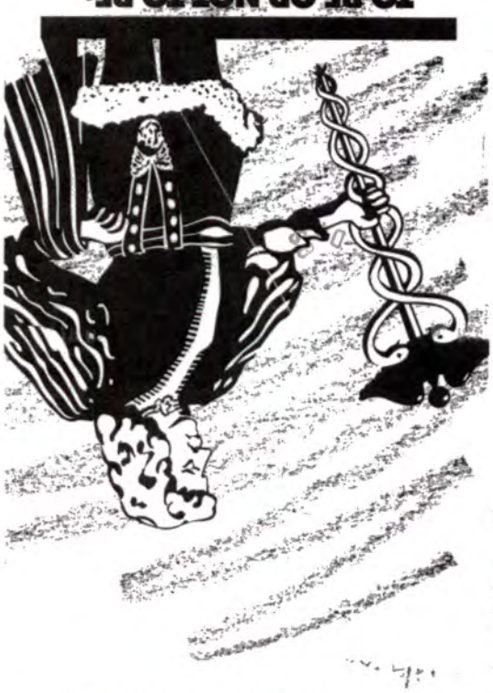
Linfield College – Portland Campus
2255 NW Northrup
Portland, OR 97210
NO REFUNDS AFTER MARCH 19



CONFERENCE ON HEALTH CARE ETHICS

TO BE OR NOT TO BE: DYING IN AN AGE OF TECHNOLOGY

APRIL 3 AND 4, 1986

HEALTH CARE ETHICS CONFERENCE
Linfield College – Portland Campus
2255 NW Northrup
Portland, OR 97210

Kristine Gebbie
Oregon State Department
of Human Resources
Salem, Or 97310

PTL
HEALTH

Sponsored by

Linfield College – Portland Campus
Linfield – Good Samaritan
School of Nursing
in conjunction with
Oregon Health Decisions

Conference address:

Linfield College – Portland Campus
2255 N.W. Northrup
Portland, Oregon

THE FIRST LINFIELD COLLEGE – GOOD SAMARITAN SCHOOL OF NURSING CONFERENCE ON HEALTH CARE ETHICS

TO BE OR NOT TO BE: DYING IN AN AGE OF TECHNOLOGY

Modern technology has created both benefits and problems in health care. Now it is possible for medical technology to extend life far beyond the point where natural processes would have brought about a termination. In cases where some hope of recovery and the re-establishment of a quality of life is possible, this capability of modern medical technology is undoubtedly of great benefit. However, the very ability to sustain life beyond its natural course can generate difficult ethical issues. What are the criteria by which one decides to continue life? This question continues to be debated in the public realm especially in health care, where the problem has a recurrent immediacy. The purpose of this conference is to explore this problem from many perspectives in order to begin to think clearly about the issues. Dying in an age of technology creates problems of the deepest moral significance. They are the concern not only of health professionals but of the public as a whole. For this reason, this conference will not only present the thoughts and ideas of experts, but will also provide the public with ample opportunities to become involved in the discussions.

VICTOR ATIYEH
GOVERNOR

Department of Human Resources
HEALTH DIVISION
1400 S.W. 5th AVENUE, PORTLAND, OREGON 97201 PHONE

DRAFT for Ecumenical Ministries of Oregon

HTLV-III Infection - A Community Challenge

Since 1981, public health agencies across the country have been responding to the challenge of understanding and controlling a new viral disease, Acquired Immunodeficiency Syndrome (AIDS), and the spread of the virus which causes it, the Human T-Lymphotrophic Virus, Type III (HTLV-III).

The virus was apparently introduced into this country into the gay community on the east and west coast probably in the mid to late 1970's. Because the first cases of the disease AIDS were made in gay men, there was an unfortunate tendency for many citizens to see this as a "gay" disease, even as a "punishment" for "gayness", or to decide that it was not ever going to be a risk to any non-gay and thus could be ignored. As information about the virus became available, there was an unfortunate over-reaction to the perceived possibility of widespread infection of the general population. As we proceed through 1986, there seems to be a lessening of fear, and, a growing understanding of the facts:

- HTLV-III, a retrovirus, is transmitted from person to person via blood and semen, through sexual intercourse, sharing of "works" for (illegal) IV drug use, other blood to blood contacts.
- HTLV-III virus is <u>not</u> spread by respiratory means, or contact with intact skin, such as would occur in ordinary household (non-sexual) contact, in schools, in workplaces.

- HTLV-III is a virus easily killed by heat or common disinfectants, but once introduced into a person's system is untreatable.
- 5-10% of those infected with HTLV-III virus develop the disease AIDS, in which destruction of the immune system leads to frequent, severe infection or other diseases, and early death, generally within 24 months of diagnosis.
- Another 10-20% of those infected develop less severe deficiences of the immune system, known as AIDS Related Complex, the long term outcome of which is not known.
- Most of those infected with HTLV-III do not show any symptoms of disease, though the lifetime outcome is not known.
- All infected persons are presumed to be capable of infecting others and need to be counselled appropriately:

  No donation of blood, semen, organs

  No sharing of needles used with drugs

  No sexual activity involving exchange of semen with uninfected individuals or with potential of injury (bleeding)

  No pregnancy

A blood test for antibodies to the HTLV-III virus, often referred to as the ELISA test, is available and in use to screen donated blood or blood products. It is also used to identify the status of concerned individuals who believe they have been infected. Public

health officials and representatives of high risk groups, especially the gay community, have emphasized that the test is not diagnostic of the disease AIDS, and the message about protection and infection is the same for all persons at risk. A negative test result may give false reassurance and lead to a resumption of risky behavior (multiple anonymous partners, sharing IV drug needles, rectal intercourse without condoms) and thus potential exposure.

There are two major areas for general community concern:

1) Education and behavior change to cut transmission of the virus
2) Provision of appropriate care and support to diagnosed AIDS or ARC patients.

Leadership for prevention education has been from public health agencies, and gay organizations. There is a huge social barrier in educating people about a disease so intimately involved in unapproved or illegal activity. There is some funding available to support educational efforts, and some printed material and a videotape are in circulation. Any interested community group can arrange for a speaker by contacting the Health Division, local health departments, Cascade AIDS, or other AIDS awareness organizations.

Care for currently diagnosed patients is not well organized. The Department of Human Resources is creating a special task force to review the needed services and barriers to their availability. Cost

of care ranges from $80,000 to $200,000 from the time of diagnosis to death. There is also a tremendous emotional cost to the patient, his family, friends and caregivers, because these are generally young men between 25 to 45 who should be planning for life, not anticipating death. Both emotional and fiscal costs can be reduced by involvement of the patient in decision-making, and by use of community resources rather than acute care hospitals. Any community group interested in exploring the need of AIDS patients and possibly contributing to meeting those needs, can make contact with support groups and the planning effort through the Health Division AIDS office.

HTLV-III infection and AIDS present an immense challenge, not just to the public health community, but to all society. I encourage Ecumenical Ministries of Oregon to carefully consider assuming an active role in meeting the challenge.

May 19, 1986

Nat. 20,766 Cases
11,384 Deaths

Oregon 85 Cases
50 Deaths

While You Were Out

To _____

Date _____ Time _____

_____ called

of _____

Phone _____

- ☐ Telephoned
- ☐ Please call
- ☐ Will call again
- ☐ In person
- ☐ Wants to see you
- ☐ Returned your call

Message _____

Taken by _____

FORM CS 97883

Recyled Paper

COMMUNITY RESPONSE TO AIDS

NO RESPONSE OUR RESPONSE HELPFUL RESPONSE

That easy trilogy covers the range of human and community response to the new infection most commonly known as "AIDS" - the name of its most extreme form. It is a new infection, apparently introduced into this country in the late 1970's, and first identified in the early 1980's.

Because it was first identified in California (and soon thereafter in New York and Florida) and because the group first identified as "victims" were unacceptable to many, the "no response" phase is fairy easy to understand. A large # of individuals including public health officials put up a large "not me, not my practice, not my town" barrier and hoped the whole thing would go away. For the general public, I think this was further fostered by our fond belief in the magic of modern science: that given any new "bug", it's only a matter of days or weeks 'til a magic bullet to care or preventing its spread will be announced.

OSHD/5/19/86

Time passed and no cure appeared - but more cases did. "AIDS" was the only form of the infection known - Acquired Immunodeficiency Syndrome - a diagnosis of last resort, in a way - one used where there was no other reason such as cancer chemotherapy to explain the suppressed immune system - the body's inability to fight infection. Two otherwise little discussed conditions became common topics in some medical circles - Kaposi's sarcoma and pneumosystic carinia pneumonia. The first is a cancer not uncommon in men over 60 of Mediterranean extraction. It was being seen in young men - it wasn't just brownish skin spots - but large tumors which became life threatening. The second is pneumonia caused by a parasite which is common and usually ignored - most of us have antibodies to it and don't know the difference. A pattern of disease became evident - one which was consistent with a communicable disease and the search for the causative organism was on.

It was at this point that "no response" moved rather quickly to "~~o~~ response". Whether from genuine concern or sensationalism, we

entered a phase which was characterized by the phrase "the deadly AIDS virus". People began imagining a return of the Black Death of the middle ages, with 1/3 to 1/2 the population wiped out. As the improved reporting system made us aware of the rapid spread of the disease, calculations were done showing how the entire U.S. population could be ill within a decade. People became concerned about the disease as "communicable" with little attention to the route of communication. Persons with AIDS, persons who looked like they might have or contract AIDS, and members of groups associated with high incidence of the disease (homosexual and bisexual men) were turned out of housing, fired from jobs, left untreated in emergencies, in general turned into 20th century lepers. Other groups were becoming involved - cases of the disease were diagnosed in recipients of blood transfusions (including an elderly nun) or blood products (including hemopheliac boys) and in infants born to infected mothers. Intravenous drug abuse was recognized as a major risk factor, especially on the East Coast. Public panic was occurring in some

places - children kept from school, and outrageous schemes to remove all likely infected persons from general circulation. Gay rights activists raged that the disease was going untreated and unresearched because of public rejection of homosexuals. Health officials quipped that AFRAIDS (Acute Fear Reaction to AIDS) was a greater threat than the disease. Comments separated "innocent victims" from those who somehow deserved their fate. But basic science research and epidemiology went on, and a fuller picture emerged - information which lets us make a helpful response to a troubling disease.

Confidentiality

FACT: The virus is not 100% deadly - only about 20% of those infected contract AIDS - which is fatal. About 15-20% contract AIDS Related Complex (ARC), a less severe form of immune problem, and at least 50% of those infected are asymptomatic carriers.

FACT: The virus is not homosexual, or drug abusing. It is a retrovirus which attacks a key cell in the immune system- one which organizes the body's response. It will do so in any blood stream to which it is introduced - by direct transmission of infected blood, or

by introduction during sexual activity in which infected blood or semen are exchanged and there is a tear or opening by which it can enter the uninfected body. Certain practices of gay men and I.V. drug abusers make these events more likely.

FACT: The HTLV-III antibody test has proven to be an effective means of screening donated blood and blood products, and organs or tissues, for potential infected donations. The act of donating is and always has been safe - and now receiving is also safe (for over 1 year). Cases still occurring do so because of the long incubation time.

FACT: The virus does not spread casually. Family members do not become ill, unless they are sex partners or share I.V. drug works". Health care workers do not sero-convert (show antibidoies) unless they have had blood exposure, and then rarely (2-3 cases) - not if they give CPR or other care.

FACT: Oregon is not immune to HTLV-III infection nor is any population group which engages in risk behaviors. We have had 85

cases (both men and women). Even if no further transmission occurred, we would expect that number to at least triple or quadruple because of the cases now incubating. We have at least 3 times that number of ARC patients, and several thousand asympotmatic carriers. The disease will continue to spread until all who are infected or might be infected have the knowledge needed to take protective action.

There are many policy questions, and programmatic questions to be answered before I will be satisfied that our helpful response is complete, but we have the skeleton in place now. It involves several key elements:

Education

Testing

Clinical Services/support

Research

Education is our best weapon against HTLV-III infection (and against overreaction). Target populations include:

Those at highest risk of infection

Health Professionals

Community leaders - as employer, as attitude shapers

School systems - to avoid problems - as a place to educate those just starting to experiment

Churches and support networks

Everyone

Local health departments and interested community groups such as Cascade AIDS Network have put in much time.

Challenge in talking in public places about semen or rectal intercourse, or safe use of I.V. drug works.

Testing - the blood supply - at every donation, <u>after</u> screening out those at highest risk.

The worried well - not to give a license to freedom but as an access to teach.

Services and support to those who are ill - society does not have good systems to deal with dying young people - and many young people are not started in their own understanding. The values of self control, at least technological, with human support, often get lip service and are being challenged.

Research -

For the magic bullet -

To treat the infections

To stop the virus

To restore the immune system

To immunize

And for the keys to behavior change -

We know it can be done short term- but our experience with other sexually transmitted diseases and smoking tell us how hard it will be.

In all of this we must struggle with the response in each of us - this disease, as much as or more than any other, brings us face to

face with our own mortality and our own sexuality, and our own prejudices and beliefs - "not me" and "not here" won't cover it up -

Our community has been generally responsive; if passive. The volunteer systems are overloaded and we must integrate the needed programs into our existing systems. I have confidence that Oregon's response will continue to be a right and helpful one.

Washington County Public Affairs Forum

P.O. Box 165 • Beaverton, Oregon 97075

ADMINISTRATOR
Oregon State Health Division

	ACTION	FYI	FILE
Admin.			
H.O.			
Exec. Asst.			
PIO			
Mgt. Asst.			
Other			

RECEIVED
APR - 3 '86

April 2, 1986

Ms. Kristine M. Gebbie
Administrator of Health
Dept. of Human Resources
711 State Office Bldg.
1400 SW 5th Avenue
Portland, Oregon - 97201

Dear Ms. Gebbie:

Thank you for accepting our invitation to speak before the Washington County Public Affairs Forum at noon on Monday, May 19th, 1986, on the subject of AIDS. A presentation of 25 to 30 minutes would be appropriate, after which we shall open the meeting to questions from members from the floor.

We meet at North's Chuck Wagon, 2785 SW Cedar Hills Blvd., (southwest corner of Cedar Hills Blvd. & Jenkins Road) in Beaverton. I have asked State Representative Mary Alice Ford to introduce the program that day. We will be pleased to have you and Mary Alice as our guests for the luncheon at noon. We normally begin our program at 12:30 p.m.

As you know, the Washington County Public Affairs Forum membership is composed of businessmen, professionals, retired persons, homemakers, and other citizens in and around Washington County who are active and/or interested in community affairs. Our programs are video-taped and rebroadcast via both Storer and Liberty Cable networks four times during the week of the program. Thus each of our programs receives considerable exposure.

We expect this May 19th program to be well attended and we look forward to hearing your presentation. Please have your secretary 'phone me at an early date, advising title you have selected for your speech.

Cordially,

William R. Buskirk, President
MAIL ADDRESS: 1775 NW 130th Ave.
Portland, Or. 97229
PHONE: 646-6382

cc: State Rep. Mary Alice Ford
6620 SW Hickman Lane
Portland, Or. 97223

HTLV-iii infection -- Perinatal Concerns

March of Dimes Symposius, Feb. 9, 1986

No slides - few statistics

Perspective - Bias toward prevention, participant in developing guidelines

HTLV-III infection, especially its extreme form AIDS, continues to receive major attention. It is a significant new public health problem. The early, exponential growwth led to calculations of the entire population of the US becoming ill; this fed the epidemic of AFRAIDS (acute fear of AIDS) No matter how important AIDS is,

It is important to keep this disease in perspective - there are 64 cases in Oregon (diagnosed since 1981, of whom 27 have died -- compare this to 100 SIDS deaths, year after year, or the growing concern about ~~rate~~ of post-neonatal death.

VERy Basic review:

this is a viral disease - HTLV-III virus -retrovirus — easy to kill outside body - the devil to get rid of inside

Regretably identified as a "gay disease" because it was first recognized in that population, and spread through it so rapidly in some cities. Allowed denial by many that it was important

Appears more easily spred there because sexual practices ~~involved sharing of semen and blood~~ Multiple anonymous partners & specific sexual acts (i.e. rectal intercourse)

The second largest group is IV drug abusers — a group with less visibility & no activist supporters

Recognition of so-called "innocent victims" helped break the perceptual barrier - recipients of blood and blood products, infants born to infected mothers.

Stopping spread of this infection requires that all presently infected persons cease any activity which might transmit the

virusto another, because there is no way to immunize the potential recipient. Cases will still increase for up to 7+ years)

1. Education, education, education. There is evidence that this is working: reduced rates of other STD's in gay population

2. Screening blood supply, and having high risk groups refrain from donating altogether.

1% of AIDS cases are pediatric - about 200 nationally. (75% in 3 places, NYC, NJ, Fla. None in Oregon to date.

We shouldn"t be smug. We guestimate 2 to 3 thousand infected Oregonians, at least some of whom are women of child-bearing age.

Is pediateric HTLV-III infection any different from adult version? No -the same range AIDS, ARC, asymptomatic. The pediatrician treating them indicate hight % at sicker end of spectrum, but there are no good studes. There are also no good studies on rate of transmission - some say as high as 50% of infected women infect child; 60% or mote on second pregnancy. Threeer is also interese oin the feffect of pregnancy on the infected woman - that it may increase her risk of developing ARC or AIDS.

Transmission - most likely in utero. 2 infected children had no contact with their mother post-delivery, one of which was a Cesearean. There is one case of apparent transmission by breast milk(Australia) There are two cases of twins (one identical, one fraternal) whrer one twin was born infected, the other not.

which can be identified today

The only sure way to stop perinatal transmission is for infected women not to have babies.

This means indentifying them prior to a decision to become pregant - sounds simple - except that the highest risk group - IV drug abusers- seldom make carefully informed decisions to become pregnant. Even a more thoughtful group - wives of hemopheliacs - when fully informed, are making decisions to risk infection in order to have a child.

Who are the women at risk:

IV drug abusers

Sex partners of IV drug abusers, bisexual men, hemopheliaces, men from high pevelance of hetosexual ssread counties (central africa, Haiti)

prostitutes

infected women

womenborn in heterosexual spread countires

What should be done:

test pre-preggnancy for informed choice about having child - how often? - counselling -

test early pregnancy for infomed choice of carrying "

test late pregnancy for info on precautions during delivery & in care of infant (including no-breast feeding)

(the ELISA test is reliable, with Western Blot backup)

Re: testing

The formal CDC paper aviods two issues debated at length be the

work group:

decisions on abortion

charges of racial genocide (SHOULD NOT be alowed to have)

Record keeping, need to know issues:

Labelling as HTLV-III positive may not be so devasting to a woman as to a man because "gayness" will not be assumed, and relsult in social stigma

Prostition and drug abuse aren't so popular, either, however

In some institutions, HTLV-III results are reported specially

Only a limited people need to know

The "Precautions" sign is for blood-born diseases, not specific to AIDS or HTLV-III infection

our reluctance to discuss

Challenge to women's health are providers:

education of women at risk

identification, testing of high risk women pre-pregnancy; counselling

identification testing & counselling of high risk woemn during preegnancy

I don't have a feel for what % of Oregon's women's health care or pericnatal providers have read the CDC guidelines, or related literatiure, and have contemplated how to incorporate them into day-to-day practice. In other areas there has been some tendency to say "not me" the preponderance of pediatric AIDS in only 3 places makes this easier. I would hope that this is not true in Oregon and that people are already evaluating their practices and taking steps to work with their high risk patients.

THE OREGON HEALTH SCIENCES UNIVERSITY

State Perinatal Project
University Hospital North
3181 S.W. Sam Jackson Park Road Portland, Oregon 97201 (503) 225-8202

25 November 1985

H.O.			
Exec. Asst.			
P.I.O.			
Mgt. Asst.	Note dates		
Other			

RECEIVED
NOV 29 '85

Kristine M. Gebbie, RN, MS
Administrator
Oregon State Health Division
P. O. Box 231
Portland, Oregon 97207

Dear Kristine,

Thank you very much for agreeing to participate in the annual March of Dimes Symposium. We think this is an ideal program stressing the preventive prenatal care topics which are considered to be high priorities now. As you recall, there will be a large group of hospital and community nurses, and this year the Symposium precedes the Family Practice Review at the Lloyd Center Red Lion by one day, so we hope to draw a large number of family practice physicians, as well.

Attached is the program which is self-explanatory. It would be very helpful if you could send us 1) a copy of your CV, and 2) one question to be used on a posttest. These things are necessary for our application for CE credits for nurses. Also, I mentioned to Claudia that I would be happy to help with slide preparation, if you'd like me to; also, if you would like to include a handout for the syllabus, we'd like to have your original by January 24th, to allow time for copying.

Thank you again, Kristine. Your participation adds a great deal to these forums, we think. If there is anything we can do to assist your staff (or you) please let me know.

Sincerely,

Gretchen

Gretchen C. Lashley

sent 12/23

(We need the CV and posttest question by December 15th, if possible. Thanks.)

Which of the following women should be screened for HTLV III antibodies?
a. all women under 50
b. women who use IV drugs
c. women with multiple sexual partners
d. women whose sex partner(s) use any IV drugs
e. women who request the test

Do you want to include a handout for the syllabus?

yes - sent 1/27/16

COR guidelines ~~+~~ we've reproduced the- Board EBd packet

March of Dimes Symposium
Sunday, 9 Feb. 1986
Lloyd Center Red Lion

SHARPENING THE FOCUS ON PRENATAL CARE

Morning Session E. Paul Kirk M.D., Moderator

8 a.m. Registration

8:45 a.m. Welcome, Introductions E.Paul Kirk MD

9:00 a.m. Infection As a Cause of Premature Labor David A. Eschenbach M.D.

9:45 a.m. AIDS And The Prenatal Patient Kristine M. Gebbie R.N., M.N.

10:20a.m. Break

10:35a.m. Hepatitis: Pregnancy Considerations Laurence R. Foster, M.D.

11:05a.m. Chlamydia and Mycoplasma During Pregnancy David A. Eschenbach M.D.

11:50a.m. Questions of morning presenters

12:10 Lunch

Afternoon Session John W. Reynolds MD, Moderator

1:10 p.m. Pre-conception Counseling Larry Veltman MD

1:45 p.m. AFP Screening in Oregon John Buckmaster MD

2:20 p.m. Break

2:30 p.m. Routine Ultrasound: New Ideas William P. Young MD

3:05 p.m. Irregular Antibodies E. Paul Kirk MD

3:40 p.m. Taking a Family History: Hereditary Conditions Neil A. M. Buist MB

4:15 p.m. Questions of afternoon presenters

4:30 p.m. Adjourn

March of Dimes Symposium

SHARPENING THE FOCUS ON PRENATAL CARE

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